

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11495

CERTIFICATE OF DEATH

11469

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Galena				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galena, Rural			
				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARTHA Middle A. Last BANKS				4. DATE OF DEATH Month October Day 28 Year 1959			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 25, 1883	
9. AGE (In years birth day) yrs. 76		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-34-3363		17. INFORMANT Esther Matthews, 526 E. 11 St. Wilm. Del.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decompensation of the heart 42a.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary occlusion DUE TO (c) Regeneration of heart muscle INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct. 9 , 19 58 , to Oct. 28 , 19 59 , that I last saw the deceased alive on Oct 26 , 19 59 , and that death occurred at 3 A. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Geza Koralewski M.D.				ADDRESS (Street, city or town, state) MILLINGTON, MD		DATE SIGNED 10. 29. 59	
PHYSICIAN'S NAME (Type) GEZA KORALEWSKI							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 31, 1959		22c. NAME OF CEMETERY OR CREMATORY Olivet Hill Cemetery		22d. LOCATION (City, town, or county) (State) Rural Galena, Kent Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward E. Miller				24a. REC'D BY REGISTRAR DATE NOV 3 '59		24b. REGISTRAR'S SIGNATURE Charles E. Kram	

11496

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall c. LENGTH OF STAY IN lb lifetime d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home - Skinners Neck		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rock Hall Rural d. STREET ADDRESS Skinner's Neck		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henrietta Elizabeth Middle Elburn Last 4. DATE OF DEATH Month Oct. Day 23 Year 1959		5. SEX female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH Sept. 19, 1869 9. AGE (In years last birthday) 90 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY home 11. BIRTHPLACE (State or foreign country) Kent Co. Maryland 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Joiner		14. MOTHER'S MAIDEN NAME Sarah C. DeFord			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		INFORMANT Address Mrs. John Boulter Rock Hall, Md. RFD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Oedema 422.1 DUE TO Cardiovascular Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c) Arterio Sclerosis DUE TO					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 17 , 19 59 to Oct 23 , 19 59 that I last saw the deceased alive on Oct 23 , 19 59 , and that death occurred at 7 P M, from the causes and on the date stated above.					
ACTUAL SIGNATURE Norbert C. Nitsch		ADDRESS (Street, city or town, state) Rock Hall, Maryland		DATE SIGNED 10/24/59	
PHYSICIAN'S NAME (Type) Norbert C. Nitsch		Rock Hall Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/26 /59		22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.	
22d. LOCATION (City, town, or county) (State) near - Rock Hall, Md.		24a. REC'D BY REGISTRAR Oct 27 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban poppers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11487

CERTIFICATE OF DEATH

Reg. Dist. No.

11471

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION High St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Amanda Middle E. Last Elliott				4. DATE OF DEATH Month Oct. Day 5 Year 1959			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1864	9. AGE (In years last birthday) 95 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Kent Co. Maryland		
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Eli Lusby				
14. MOTHER'S MAIDEN NAME Sarah Jpiner			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO. no			17. INFORMANT Miss Catherine Elliott Address Chestertown, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 422.2 DUE TO Myocarditis, chronic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Old age DUE TO DUE TO 						INTERVAL BETWEEN ONSET AND DEATH 10 days 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 	(County) 	(State) 		
21. I certify that I attended the deceased from November , 19 55 , to October , 19 59 , that I last saw the deceased alive on September 15 , 19 59 , and that death occurred at 10:00p , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Chestertown, Md.						DATE SIGNED 10-6-59	
ACTUAL SIGNATURE A. C. Dick		PHYSICIAN'S NAME (Type) A. C. Dick					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/8 /59	22c. NAME OF CEMETERY OR CREMATORY Chester Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells			ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR oct 8 59	24b. REGISTRAR'S SIGNATURE 	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11472

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Chestertown c. LENGTH OF STAY IN 1b 6 months 1 year d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Tolchester Beach for 20 years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY Sarasota - 6 months to the year c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sarasota - 6 months to the year d. STREET ADDRESS 48x-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Edward Wm. Garman		4. DATE OF DEATH Month Day Year Oct. 5, 1959 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1895
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Pork Salesman		10b. KIND OF BUSINESS OR INDUSTRY Pottstown, Pa.	
11. BIRTHPLACE (State or foreign country) Pottstown, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Garman		14. MOTHER'S MAIDEN NAME Dont Know	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 362-16-8011	
17. INFORMANT Mrs. Martha Garman		18. ADDRESS Tolchester Beach Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH one hour			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> at 9:00A.M.			
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Robert W. Farr		DATE SIGNED 10/5/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 8, 1959	
22c. NAME OF CEMETERY OR CREMATORY Morris Cemetery		22d. LOCATION (City, town, or county) (State) Phoenixville, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE OCT 7 '59		24b. REGISTRAR'S SIGNATURE Arthur G. Kneass	

11498
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 3 FilmG251 11-13-59 et
 CERTIFICATE OF DEATH

11473

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Galena				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Galena			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NOLAND Middle Dennis Last HACKETT				4. DATE OF DEATH Month October Day 20 Year 19 59			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1890		9. AGE (In years last birthday) yrs. 69	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butler, Private Home		10b. KIND OF BUSINESS OR INDUSTRY Butler		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anthony Hackett				14. MOTHER'S MAIDEN NAME Emma Topsisie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 166-28-9413		17. INFORMANT Mrs. Viola Hackett,		Address Galena, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c) Degeneration of the heart muscle						INTERVAL BETWEEN ONSET AND DEATH immediate 2-3 yrs. 2-3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 19, 1959 to Oct 20, 1959 , that I last saw the deceased alive on Oct 20, 1959 , and that death occurred at 2:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John Koralewski				ADDRESS (Street, city or town, state) MILLINGTON, MD		DATE SIGNED 10-21-59	
PHYSICIAN'S NAME (Type) JOSEPH KORALEWSKI							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 25, 1959		22c. NAME OF CEMETERY OR CREMATORY Olivet Hill Cemetery		22d. LOCATION (City, town, or county) (State) Rural Galena, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward F. House				ADDRESS Millington, Md.		24a. REC'D BY REGISTRAR DATE OCT 26 '59	
				24b. REGISTRAR'S SIGNATURE M. L. S. House			

11499

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rich Hall		c. LENGTH OF STAY IN lb 12 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Rich Hall	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allen Lane		d. STREET ADDRESS Allen Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Otto		First Middle Last Hamann		4. DATE OF DEATH Oct. 4 1959	
5. SEX M.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH June 6, 1897		9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sea Captain		10b. KIND OF BUSINESS OR INDUSTRY Merchant Marine		11. BIRTHPLACE (State or foreign country) Schönberg Germany	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 181-09-8561		17. INFORMANT William F. Hamann	
Address 1886 N. Grand		Baldwin, N. Y.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Astoria & Pulverosis - (c) Pneumonia. Emphysema		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1954, to Oct 4, 1959, that I last saw the deceased alive on Oct 3, 1959, and that death occurred at 5:40 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Nashua & C. Nitch M.D. Rich Hall Ind. No B BERT-C-NITSCHE Rich Hall Ind.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 6 / 59		22c. NAME OF CEMETERY OR CREMATORY Wickes Chapel Cn.	
22d. LOCATION (City, town, or county) (State) Rich Hall Kent Co. Ind.		23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams - Chesterton, Ind.		24a. REC'D BY REGISTRAR DATE OCT 8 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Krause					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

11-28

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF BIRTH 12-5-24		5. PLACE OF BIRTH MOBILE, ALABAMA		6. OCCUPATION None	
7. MARITAL STATUS Single		8. COLOR White		9. RELIGION None	
10. DATE OF DEATH 6-4-68		11. PLACE OF DEATH FBI, MOBILE, ALABAMA		12. CAUSE OF DEATH Suicide by gunshot	
13. MANNER OF DEATH Suicide		14. SIGNATURE OF DECEASED (None)		15. SIGNATURE OF WITNESS (None)	
16. SIGNATURE OF PHYSICIAN (None)		17. SIGNATURE OF CORONER (None)		18. SIGNATURE OF JUDGE (None)	
19. SIGNATURE OF CLERK (None)		20. SIGNATURE OF REGISTRAR (None)		21. SIGNATURE OF NOTARY (None)	



RECEIVED
JUN 10 1968
BALTIMORE, MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11488

CERTIFICATE OF DEATH

11475

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN lb 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital				d. STREET ADDRESS Rock Hall, Catholic Avenue			
3. NAME OF DECEASED (Type or print) First Wilbur Middle Joiner Last Joiner				4. DATE OF DEATH Month 10 Day 21 Year 19 59			
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED XX DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/15/1888		9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR Months 71 Days 21 Hours 19 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert Joiner				14. MOTHER'S MAIDEN NAME Annie Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT		Address Rock Hall, Md. Hospital Records Chestertown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO XX
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/8 , 19 59 , to 10/21 , 19 59 , that I last saw the deceased alive on 10/21 , 19 59 , and that death occurred at 1:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE A.C. Dick				ADDRESS (Street, city or town, state) CHESTERTOWN, MD. DATE SIGNED 10/21/59			
PHYSICIAN'S NAME (Type) A.C. Dick				Chestertown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/24/59		22c. NAME OF CEMETERY OR CREMATORY Weekly Chapel		22d. LOCATION (City, town, or county) (State) Rock Hall Md	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane				ADDRESS Church Hill		24a. REC'D BY REGISTRAR OCT 28 '59 DATE	
						24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

NOTES: STATE OF NEW YORK, COUNTY OF WESTCHESTER

2357

Revised: 10/1/98

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11489

CERTIFICATE OF DEATH

11476

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent on Queen Ann</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence Kenneth Kennard</u>				4. DATE OF DEATH Month Day Year <u>Oct 14 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 13 - 1959</u>	9. AGE (In years last birthday) <u>Newborn</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>14 10</u>		IF UNDER 24 HRS. <u>14 10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>n ne</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>n ne</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Clark Edward Kennard</u>				14. MOTHER'S MAIDEN NAME <u>Elsie Mae Ford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Hospital Records * Chestertown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) <u>Prematurity (Immaturity)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Hour o. m. p. m. <u>— 19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) <u>—</u>		(County) <u>—</u>	(State) <u>—</u>
21. I certify that I attended the deceased from <u>Oct. 13, 1959</u> , to <u>Oct 14, 1959</u> , that I last saw the deceased alive on <u>10-13-59</u> , 19 <u>59</u> , and that death occurred at <u>7³⁰ AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Oskar Gulbrandsen M.D.</u>				ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Oskar Gulbrandsen M.D.</u>				DATE SIGNED <u>10-14-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/14/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Janes Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>near Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. W. Chestertown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

2072302XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11-88

STREET OF DEATH NO.		CITY OF DEATH STATE OF DEATH	
NAME OF DECEASED SEX		AGE DATE OF BIRTH	
OCCUPATION PLACE OF BIRTH		DATE OF DEATH TIME OF DEATH	
CAUSE OF DEATH ICD-9 CODE		MANNER OF DEATH () NATURAL () ACCIDENT () SUICIDE () HOMICIDE	
PLACE OF DEATH () HOME () HOSPITAL () NURSING HOME () OTHER		SIGNATURE OF DECEASED SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN DATE		SIGNATURE OF CORONER DATE	
SIGNATURE OF REGISTRAR DATE		SIGNATURE OF CLERK DATE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11490

CERTIFICATE OF DEATH

11477

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown	
c. LENGTH OF STAY IN 1b plus 25 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home - Campus Ave.		d. STREET ADDRESS Campus Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Howard D. Middle Knotts Last		4. DATE OF DEATH Month Oct. 2, Day 1959 Year 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 13, 1877
9. AGE (In years last birthday) yrs. 82		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman		10b. KIND OF BUSINESS OR INDUSTRY Tobacco	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Wesley Knotts		14. MOTHER'S MAIDEN NAME Chaffinch Mary Frances Chaffinch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Susie Knotts		Address Campus Ave. Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Possible Ventricular Fibrillation (c) Probable Coronary Thrombosis or Cardiac			INTERVAL BETWEEN ONSET AND DEATH short
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Found dead in bed and estimated 2 hours after death			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5/11 , 19 56 , to 10/2 , 19 59 , that I last saw the deceased alive on 10/2 , 19 59 , and that death occurred at 7 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert W. Farr		ADDRESS (Street, city or town, state) DATE SIGNED Chestertown, Md. 10/3/59	
PHYSICIAN'S NAME (Type) Robert W. Farr, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/4/59	22c. NAME OF CEMETERY OR CREMATORY Greenmount Cem.	22d. LOCATION (City, town, or county) (State) Hillsboro, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		24a. REC'D BY REGISTRAR DATE OCT 6 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hines

CERTIFICATE OF DEATH

1910

NAME OF DECEASED JOHN WESLEY HOBBS		SEX Male		AGE 35		DATE OF BIRTH May 12, 1875		PLACE OF BIRTH Maryland	
RESIDENCE 1110 N. E. Ave.		OCCUPATION Clerk		EDUCATION High School		RELIGION Roman Catholic		MARRIAGE Married	
CAUSE OF DEATH Tuberculosis of lungs		PERIOD OF ILLNESS 3 months		PLACE OF DEATH Home		DATE OF DEATH July 15, 1910		TIME OF DEATH 10:30 AM	
SIGNATURE OF PHYSICIAN J. H. Jones, M.D.		SIGNATURE OF WITNESSES J. H. Jones, M.D. J. H. Jones, M.D.		SIGNATURE OF DECEASED John Wesley Hobbs		SIGNATURE OF NEAREST RELATIVE Mrs. Susan Hobbs		SIGNATURE OF CLERK J. H. Jones, M.D.	
REGISTRATION NO. 1110 N. E. Ave.		FILE NO. 1110 N. E. Ave.		DATE OF REGISTRATION July 15, 1910		PLACE OF REGISTRATION Baltimore		OFFICE OF REGISTRATION Baltimore	

RECEIVED
JUL 16 1910
BALTIMORE

11500
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 22 Film G249 10-14-59 et
 CERTIFICATE OF DEATH

Reg. Dist. No.

11478

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Kennedyville				c. LENGTH OF STAY IN 1b 2 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville			
3. NAME OF DECEASED (Type or print) First Middle Last Ella Luff				4. DATE OF DEATH Month Day Year October 11 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 17, 1882	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) N. Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Shirley Hutson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Rosie Hurt Kennedyville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acut Pulmonary Edema 430.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion DUE TO (c) Arterio-sclerotic cardiovascular disease							INTERVAL BETWEEN ONSET AND DEATH 15 Min. 1 hour 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the stomach							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from August, 1957 , to Oct 11, 1959 , that I last saw the deceased alive on Oct 8, 1959 , and that death occurred at 9 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Florence Deringer Joyce M.D. 10-11-59							
ACTUAL SIGNATURE Florence Deringer Joyce M.D. Worton, Md.							
PHYSICIAN'S NAME (Type) Florence Deringer Joyce							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/14/59		22c. NAME OF CEMETERY OR CREMATORY Goldsboro Cemetery		22d. LOCATION (City, town, or county) (State) Goldsboro, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy				ADDRESS Still Pond, Md.		24a. REC'D BY REGISTRAR DATE OCT 13 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

11491

CERTIFICATE OF DEATH

11479

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 50 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle G. Last Petry		4. DATE OF DEATH Month Oct. Day 25 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 4, 1883
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min.	11. IF UNDER 24 HRS. Months 76 Days 76 Hours 76 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY owner	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Germany ✓	
13. FATHER'S NAME Carl Petry		14. MOTHER'S MAIDEN NAME Anna Schlingenziepen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Yes.	
17. INFORMANT Mary Perty - Chestertown, Md.		Address RFD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 151X DUE TO CARCINOMA OF STOMACH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-23-59 to 10-25-59 that I last saw the deceased alive on 10-25-59 , 19, and that death occurred at 6:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 10/25/59			
ACTUAL SIGNATURE A. S. GULBRANDSEN		M.D. A. S. GULBRANDSEN, M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 28, 1959	
22c. NAME OF CEMETERY OR CREMATORY Chester Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE OCT 28 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DEATH

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11501
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) THOMAS First RANKIN Middle Last		4. DATE OF DEATH Month October Day 4 Year 1959	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1898
9. AGE (In years last birthday) 61		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Labor		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-18-4345A	
17. INFORMANT Verma D. Rogers,		Address Millington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thyrocardial Insufficiency 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Renal Insufficiency		INTERVAL BETWEEN ONSET AND DEATH 10 yrs 10 yrs 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchial Asthma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 11, 1959 to Oct 4, 1959 , that I last saw the deceased alive on Oct 2, 1959 and that death occurred at 7:45 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE H. H. Hamilton		M.D. Millington Md DATE SIGNED 10/6/59	
PHYSICIAN'S NAME (Type) H. H. HAMILTON			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 7, 1959	22c. NAME OF CEMETERY OR CREMATORY Golt Cemetery	22d. LOCATION (City, town, or county) (State) Golt, Kent Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Bellows, Millington, Md.		24a. REC'D BY REGISTRAR DATE OCT 9 '59	24b. REGISTRAR'S SIGNATURE Charles E. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11492

CERTIFICATE OF DEATH

11481

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Still Pond</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent and Queen Anne's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>Blanche</u> Last <u>Redding</u>		4. DATE OF DEATH Month <u>October</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 12, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>9</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Gibbs</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-12-1973</u>	
17. INFORMANT <u>Mary Simmons, Duttonville Still Pond, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>5 years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-23</u> , 19 <u>59</u> , to <u>10-23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-23</u> , 19 <u>59</u> , and that death occurred at <u>8:24 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.C. Dick</u> M.D.		ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u> DATE SIGNED <u>10-23-59</u>	
PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/25/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Still Pond (colored)</u>	22d. LOCATION (City, town, or county) (State) <u>Still Pond, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Wadley</u> ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR <u>OCT 27 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11-92

NAME OF DECEASED [Faint text, possibly "JOHN J. SMITH"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		DATE OF DEATH [Faint text, possibly "Nov 10 1911"]	
PLACE OF DEATH [Faint text, possibly "Home"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
OCCUPATION [Faint text, possibly "Clerk"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF CORONER [Faint signature]	
SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF DECEASED [Faint signature]	
PLACE OF BIRTH [Faint text, possibly "Maryland"]		DATE OF BIRTH [Faint text, possibly "Nov 10 1866"]	
PLACE OF DEATH [Faint text, possibly "Home"]		DATE OF DEATH [Faint text, possibly "Nov 10 1911"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF CORONER [Faint signature]	
SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF DECEASED [Faint signature]	

1

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE CITY AND COUNTY OF BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE CITY AND COUNTY OF BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE CITY AND COUNTY OF BALTIMORE, MARYLAND.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11502

CERTIFICATE OF DEATH

11482

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Betterton				c. LENGTH OF STAY IN 1b 30 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Raymond Middle Earle Last Stone				4. DATE OF DEATH Month October Day 8 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 20, 1891		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 8 Days 8 Hours 8 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance				10b. KIND OF BUSINESS OR INDUSTRY Public Schools		11. BIRTHPLACE (State or foreign country) Delaware	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Walter Henry Stone				14. MOTHER'S MAIDEN NAME Sarah Ellen Ash			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-01-7840A		17. INFORMANT Helen Stone Address Nazareth, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia because of radiation sickness 201x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hodgkin's Disease DUE TO (c) Coronary Insufficiency						INTERVAL BETWEEN ONSET AND DEATH 2 Months 2 years 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary insufficiency						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 10, 1953 , to Oct 8, 1959 , that I last saw the deceased alive on Oct 8, 1959 , and that death occurred at 4:52 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Florence Deringer Joyce M.D.				ADDRESS (Street, city or town, state) Worton, Md. DATE SIGNED Oct. 9, 1959			
PHYSICIAN'S NAME (Type) Florence Deringer Joyce, M. D.				Worton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/11/59		22c. NAME OF CEMETERY OR CREMATORY Still Pond Cemty		22d. LOCATION (City, town, or county) (State) Still Pond, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy				ADDRESS Still Pond, Md.		24a. REC'D BY REGISTRAR DATE OCT 13 '59	
				24b. REGISTRAR'S SIGNATURE Arthur E. Hines			

CERTIFICATE OF DEATH

11502

Name of Deceased Florence M. Jones		Date of Death August 20, 1901	
Place of Birth Boston, Mass.		Age 50 years	
Sex Female		Race White	
Cause of Death Apoplexy		Date of Burial August 22, 1901	
Name of Physician Dr. J. M. Jones		Name of Undertaker J. M. Jones	
Name of Burial Place Mount Hope Cemetery		Name of Minister Rev. J. M. Jones	
Name of Next of Kin Mr. J. M. Jones		Name of Informant J. M. Jones	
Signature of Registrar J. M. Jones		Signature of Minister J. M. Jones	
Date of Registration August 22, 1901		Date of Burial August 22, 1901	



MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

11493

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent Kent & Queen Anne's Hospital <small>MARYLAND</small>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY in 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS Galena	
3. NAME OF DECEASED (Type or print) Charles Edward Stradley		First Middle Last		4. DATE OF DEATH 10 19 19 59		Month Day Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/13/1888	9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY General Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Thomas Stradley				14. MOTHER'S MAIDEN NAME Emma Redgrave			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 218-07-3784		INFORMANT Mrs. Fred Boyles		Address Galena, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarct 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Atherosclerotic Cardiovascular disease DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/18/59 , 19____, to 10/19/59 , 19____, that I last saw the deceased alive on 10/19/59 , 19____, and that death occurred at 7:35 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE William M. Gaturay M.D.				ADDRESS (Street, city or town, state) Rock Hall, Md.		DATE SIGNED 10/19/59	
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/21/59		22c. NAME OF CEMETERY OR CREMATORY GEORGETOWN, CEM.		22d. LOCATION (City, town, or county) (State) GEORGETOWN, KENT Co., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward E. ...				24a. REC'D BY REGISTRAR OCT 23 '59		24b. REGISTRAR'S SIGNATURE Arthur L. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[Faint handwritten notes at the bottom of the page]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11484

11494

1. PLACE OF DEATH: a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b less than 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville, M(Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Annes (emergency room)				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Lusby Last Sutton Jr.				4. DATE OF DEATH Month October Day 1 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 24, 1948		9. AGE (In years last birthday) 11 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Student		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James L. Sutton, Sr.				14. MOTHER'S MAIDEN NAME Marian Burris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 		17. INFORMANT James L. Sutton, Sr. (father) Address Kennedyville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing injuries to right side of chest caused by tractor falling on him. DUE TO 835x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Went out to drive in cows on farm tractor at 4:30 PM. Was found at 5:15 PM with steering wheel pinning right side of chest to the ground. Died 3 1/2 hours later despite all measures. (c) INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) See above					
20c. TIME OF INJURY 4:30 How XXX. p. m. Oct 1 19 59	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) farm near		20f. (City or town) Kennedyville		(County) Kent	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Robert W. Farr M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Robert W. Farr				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/3/59		22c. NAME OF CEMETERY OR CREMATORY SHREWSBURY CEM. RURAL		22d. LOCATION (City, town, or county) (State) Kennedyville MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Hellows				24a. REC'D BY REGISTRAR OCT 5 1959		24b. REGISTRAR'S SIGNATURE Arthur A. Harris	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

